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ABSTRACT

Behavior modification and behavior therapy techniques with institutionalized and community elderly are powerful approaches which effect changes in behavior quickly and dramatically, and are particularly useful because they involve total staff or family members in their implementation. Unlike psychotropic medications, behavioral approaches do not leave clients unresponsive or disoriented, but instead, focus on target symptoms and deal with these symptoms by manipulation of the social and physical environment of the client. Training in the use of these techniques is straight forward; minimum jargon is required and procedures can be laid out in easily understood steps. Positive results effect heightened morale for all concerned as situations which were previously viewed as hopeless readily resolve as a consequence of the behavioral interventions. In the work that has been done, the power and potential of these approaches for the reversal of nihilistic and ageistic attitudes, treatment of disruptive behaviors, interpersonal conflicts, and decreased motivation for self-care and self-improvement are well documented. Several such approaches are illustrated. (Author)

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PSYCOTHERAPY WITH ELDERLY CLIENTS: A BEHAVIORAL APPROACH*

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It is clear that individual or group psychodynamically-oriented psychotherapy has the potential for effecting changes in attitudes and behaviors of older people. However, it is obvious to anyone who has worked in an institutional setting that these techniques are not applicable with residents who posses moderate or severe degrees of cognitive deficits. For this more impaired group, behavioral techniques which manipulate social and physical environmental variables have shown much promise.

In the interest of time, I will review only a few of the studies and refer you to the comprehensive review of behavioral approaches with geriatric clients compended by Hoyer, et. al. (1975), Riedel (1974), and Rook (1974). I shall then go on to describe some of the benefits and problems we have encountered in using these techniques in a clinical setting. Although we have not yet had the opportunity to formally evaluate these approaches, we have had a high "hit rate." Referring physicians and ancillary staff have developed increasing interest in the approaches and the number of requests for behavioral interventions have shown a steady increase over time.

Many recent studies have illustrated the usefulness of even relatively trivial environmental manipulations in effecting marked behavioral changes in institutionalized older people. McClannahan and Risley (1975) introduced simple puzzles and games and demonstrated that prompting their use trebles activity level in nursing home residents. Geiger and Johnson (1974) effected appropriate meal consumption by providing additional dessert, additional time spent with staff, or "any reasonable gift" if the evening meal was eaten. Langer and Rodin (1976) showed that a communication given to nursing home residents, emphasizing their responsibility for themselves,

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freedom to make choices, responsibility for caring for a green plant produces significant improvements in alertness, active participation, and general sense of well-being. Furthermore, these changes were sustained over an eighteen month period of time.

On another level, more complex behavior modification techniques have shown promise in their ability to decrease maladaptive behavior and increase adaptive functioning. Token economy programs (Libb and Clements, 1969; Sachs, 1975) have been used to positively affect exercise in physical therapy programs, walking, oral hygiene, and social interaction, and to decrease isolate behavior. MacDonald and Butler (1974) found that verbal and nonverbal prompts and the extension or withholding of praise were related to an increase of walking and lessened wheel-chair activity in institutional subjects. Reestablishment of self-feeding (Baltes and Zerbe, 1976) and control of screaming behavior (Baltes and Lascomb, 1975) were favorable outcomes resulting from the application of consistent reinforcement in two nursing home cases. On the other hand, effective control of incontinence with similar techniques has been elusive (Pollock and Lieberman, 1974; Collins and Plaska, 1975.)

The focus of this presentation will be on the application of behavior modification techniques to institutional elderly and the potential of these techniques for reversing the nihilistic attitudes that frequently are present in institutional settings. These behavioral approaches are especially powerful in this regard because they effect changes in behavior quickly and dramatically and because they involve all unit staff in their implementation. Staff training in the use of these approachs is straightforward. Minimum jargon is required and procedures can be laid out in

easily understood steps. Staff morale is usually heightened since therapeutic success is clearly due to a consistent team effort and staff members feel that they now can have some control over situations that they previously viewed as hopeless.

Successful application of behavioral techniques can therefore produce positive changes in both staff and residents' attitudes and behaviors. Institutionalized elderly who are behaving in maladaptive fashions try the patience of even the most competent staff. Typically, there is a feeling that nothing can be done for these residents other than to use psychotropic drugs and frequently the solution seems to be to simply to bear up as well as one can with their aversive behaviors or discharge these residents to different facilities. Disruptive residents quite naturally evoke anger from staff and other residents and communication quickly breaks down. Quality of care has to suffer as a result. Staff time is often used to excess in dealing with disruptive behavior rather than in providing necessary services to all residents. These residents are often quickly labeled as organic brain syndrome with the implication of an irreversible process which is not susceptible to intervention. Rook (1974) suggests that their deficits can be more heuristically viewed as involving environmental factors which can be modified to affect positive changes. Lindsley (1964) has stated that free-operant techniques are useful in differentiating whether the behavior is due to brain impairment or to environmental-induction.

In many cases, over the past three years, we have seen remarkable shifts in attitudes towards the disruptive resident once a behavioral program was initiated. In addition, a reduction in the overall tension level on the floor is apparent and staff verbalize surprise at their ability to deal with problems that initially were overwhelming or that appeared to be

irremediable.

The advantages of behavior modification approaches over use of psychotropic drugs are clear. With older persons, issues of drug interactions, toxicity, and appropriate dosage are hotly debated and, at this point, unresolved. There clearly is a place for this therapeutic modality in certain circumstances; however, drugs should not be used simply because they are more convenient, or require less investment of staff time. In addition, psychotropic drugs often leave the individual heavily sedated, disoriented, and unapproachable. Behavior modification procedures, on the other hand, are directed toward specific behaviors which are a problem for the individual and attempt to deal with these by manipulation of the physical and social environments. They address target symptoms and can be carefully monitored and modified when necessary so that the therapy is tailored to specific maladaptive behaviors of the resident. The behavioral program requires a good deal more time than drug administration, at least initially. Most of this time is expended on training staff in basic behavioral principles and techniques. Once this is accomplished and the staff receive positive feedback from initial success with the technique there is more time available to set up and monitor programs. Occasional staff meetings are then sufficient to attack problems as they arise with programs in process or for orientation to new programs.

Behavior modification approaches can be used across a wide range of functioning and either in conjunction with other therapeutic approaches or on their own. The techniques, as mentioned previously, appear to be particularly applicable to lower functioning elderly who would not usually be able to benefit from the more traditional therapeutic approaches. The behavioral approach requires a cooperative staff so that programs are

implemented consistently. In addition, some period of time spent in training staff in the rationale and use of behavioral techniques in general is desirable. Both when education staff and when implementing programs it is important to convey and reinforce an optimistic approach to the problems.

Mishara, Robertson and Kastenbaum (1973) have described a five step procedure that may be applied to geriatric intervention: observation, reflection, intervention, assessment, and follow-up. Rather than focus on the step by step implementation of the program in our setting, I will concentrate on particular problems with some of the steps.

For our population, the reflection component presents the most challenge. Hoyer, Mishara, and Riedel (1975) recommend that in this step, the intervention be designed and evaluated in terms of two criteria: first, is it the best possible intervention approach for this individual at this time in this situation? Second, is it appropriate and humane to apply this particular intervention approach? The latter is a particularly sensitive issue. Guidelines for using these techniques ethically are available (Ennis, 1971; Wexler, 1973) and should be required reading for the therapist. We have operated successfully without using aversive procedures and see no need to use them. Our emphasis has been on rewarding appropriate behaviors and ignoring or intervening non-aversively when maladaptive behaviors are expressed.

Finding effective positive reinforcers for institutionalized older people continues to be a problem. Two that appear to be the most effective are attention and praise. We have made a point of incorporating these in every program by having staff make a point of interacting with the resident when he or she is behaving appropriately. It is far too easy in institutional settings to ignore adaptive behaviors; a part of staff training must present the balance between non-reinforcement of negative and reinforcement of

positive behaviors, and work toward their acceptance of the extra work that may be required to reinforce positively in the absence of "problem" behavior. In some cases, a careful review of the chart and a conference with family members can lead to specific reinforcers for a particular resident. For example, for one older person, the opportunity to get dressed up in his best suit, vest, and hat was quite motivating. This was used in addition to praise and attention to achieve goals in a rehabilitation program.

At the intervention point, it is often helpful to have the behavioral consultant available to model appropriate responses for the staff and to insure correct and consistant application by monitoring staff-resident interactions. Periodic assessment of progress is particularly important during early program stages. Staff frequently are prone to become discouraged if the resident does not show immediate gains. For example, certain attention-drawing maladaptive behaviors are likely to increase for a short period when they are ignored by staff. Again, at least initially, education sessions provided by the optimistic behaviorist go a long way to resolve problems and to change programs if necessary.

In terms of follow-up, it is necessary with more highly impaired older people to provide a prosthetic environment (Lindsley, 1964) if higher levels of functioning are to be sustained. These individuals are highly sensitive to the shifts in physical and social environments that are components of a behavioral program. Lawton (19) has expressed this as the "environmental docility hypothesis"; that is, as the competence of the individual decreases, the proportion of behavior attributable to environmental, as contrasted with personal, characteristics increases. Although these shifts then can have significant effects on behavior, it is usually difficult and would be inefficient for staff to maintain for extended

periods of time the high degree of involvement and interaction required during the actual behavioral programs. Residents do require periodic "intensive care" to sustain higher functioning levels, but each successive "program" appears to require less effort and time than the previous one to return the resident to this higher level. Lawton (1978) has argued that behavioral and environmental psychologists may, by their collaboration, effect longer term changes in behavior by modifications of the physical environment in which the elderly person resides. This approach would go a long way toward relieving us of depending exclusively upon the social environment in effecting change.

We can illustrate the use of the behavioral approach most easily by presenting a typical case. Mrs. G, a 73 year old woman, engaged in almost constant screaming, and psychotic-like rambling. She was highly disruptive, to the extent that other residents and their families were anxious to have her discharged from the floor. In addition, staff perceived her to be highly manipulative and completely uncontrollable; everything that had been tried, including psychotropic medication, had failed. At the time of the request for behavior modification, she was kept in her room with the door closed for long periods of time. Meals were brought to her, and she required the services of a private-duty nurse for help in self-care activities. Her sleep was often disturbed, and she would remain awake for several days before collapsing for almost as long.

Staff members were convinced that nothing could be done to improve the situation; at the initial staff meeting, a good deal of time was spent recognizing and accepting the staffs' negative attitudes toward the woman. At the same time, the behavioral consultant adopted an attitude of confidence and optimism and assured the staff that it would be able to gain control over the woman's aversive behaviors in a short time. It was reported that Mrs. G. became noisier at certain times of the day, especially when her private-duty nurse would leave her. Also, the more loudly she yelled, the more difficult it became to understand her. She appeared to be continually agitated, and her psychotic verbalizations were bizarre and frightening to the staff.

The program, as outlined to the staff, was designed to be easily understandable, with a good chance of being consistently implemented. The following five items were circulated to staff for review:

a. When speaking with Mrs. G., if she speaks loudly say: " I CAN'T HEAR YOU" When she becomes quieter say: "IT'S SO MUCH BETTER WHEN YOU SPEAK SOFTLY AND SLOWLY, I CAN UNDERSTAND EVERY WORD YOU SAY"

b. When she begins to talk bizarrely: Interrupt and change the topic. Ask her what she ate at the last meal, who visited her last weekend, what activities she has an interest in, etc. Substitute reality-oriented topics of conversation.

c. Each staff member should spend some period of time each day sitting and talking with Mrs. G. practicing what has been outlined in the first two steps. Use touch and make encouraging statements when she is responding appropriately. Speak softly at all times. Model appropriate behavior for her even when correcting her actions.

d. Keep her in public space as much as possible. If necessary, take her to her room for short periods indicating to her that she can return to the public space if she can be quiet for a short time.

e. Keep track of any progress or difficulties; program will be checked and changed if necessary

Initially, the behavioral consultant modelled the appropriate responses for the staff. During the first day, the resident was able to remain outside her room for several hours, and the screaming behavior was markedly reduced. Within several days the psychotic verbalizations became less evident and staff felt comfortable dealing with her when they did arise, since she responded well to reality-oriented shifts in the conversation. On no occasion after the program started did Mrs. G. have to be brought back to her room for disruptive behavior.

Mrs. G. continued to show good progress and staff began to genuinely like her. It became easier for them to interact with her since she was speaking appropriately and was much more reality-oriented. Mrs. G. gradually began to interact with other residents and often would help in feeding those who required assistance. She also was able to take more responsibility for her own care. These changes have been sustained now for several months.

In summary, behavior modification approaches show promise for institutionalized

older people who are having psychosocial difficulties. Their unique contribution appears to be in involving the total staff as a therapeutic team in dealing with maladaptive behaviors. Staff morale is frequently heightened and nihilistic attitudes are continually challenged as these programs are applied to more and more residents successfully.

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